Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

Bevacizumab in combination with capecitabine for the first-line treatment of metastatic breast cancer.

Bibliographic Source(s)

National Institute for Health and Clinical Excellence (NICE). Bevacizumab in combination with capecitabine for the first-line treatment of metastatic breast cancer. London (UK): National Institute for Health and Clinical Excellence (NICE); 2012 Aug. 48 p. (Technology appraisal guidance; no. 263).

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

Bevacizumab in combination with capecitabine is not recommended within its marketing authorisation for the first-line treatment of metastatic breast cancer, that is, when treatment with other chemotherapy options including taxanes or anthracyclines is not considered appropriate, or when taxanes or anthracyclines have been used as part of adjuvant treatment within the past 12 months.

People currently receiving bevacizumab in combination with capecitabine that is not recommended according to the above statement should have the option to continue treatment until they and their clinician consider it appropriate to stop.

Clinical Algorithm(s)

This guidance has been incorporated into a NICE Pathway for advanced breast cancer, along with other related guidance and products, on the National Institute for Health and Clinical Excellence (NICE) web site .

Scope

Disease/Condition(s)

Metastatic breast cancer

Guideline Category

Assessment of Therapeutic Effectiveness

Treatment

Clinical Specialty

Internal Medicine

Obstetrics and Gynecology

Oncology

Intended Users

Advanced Practice Nurses

Nurses

Physician Assistants

Physicians

Guideline Objective(s)

To assess the clinical effectiveness and cost-effectiveness of bevacizumab in combination with capecitabine for the first-line treatment of metastatic breast cancer

Target Population

Adults with human epidermal growth factor receptor 2 (HER2)-negative metastatic breast cancer previously untreated in the metastatic setting:

- For whom treatment with other chemotherapy options, including taxanes or anthracyclines, is not considered appropriate
- Who have not received taxane or anthracycline-containing regimens in the adjuvant setting within the last 12 months

Interventions and Practices Considered

Bevacizumab in combination with capecitabine

Major Outcomes Considered

- Clinical effectiveness
  - Overall survival (OS)
  - Progression free survival (PFS)
  - Response rates (complete and partial)
  - Adverse effects (AEs)
  - Health-related quality of life (HRQoL)
- Cost effectiveness

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare an assessment report. The Evidence Review Group (ERG) report for this technology appraisal was prepared by Liverpool Reviews and Implementation Group (LRiG) (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Literature Searches

The manufacturer described the literature searches conducted on 14th and 15th November 2011. Searches were conducted to identify relevant randomised controlled trials (RCTs). There were no additional searches for identifying adverse effects (AEs) or non-RCT evidence. No searches were conducted to identify studies for indirect and/or mixed treatment comparisons as such analyses were not deemed necessary by the manufacturer.

Major electronic databases were searched including MEDLINE, BIOSIS, EMBASE, and the Cochrane Library. All clinical abstracts for the past two years from relevant American Society of Clinical Oncology (ASCO), San Antonio Breast Cancer Symposium (SABC) and European Cancer Organisation (ECCO)/European Society for Medical Oncology (ESMO) abstracts were also reviewed. The search strategy used index and text words which included bevacizumab, capecitabine and breast cancer as descriptors and was limited to studies published in English and relating to humans and clinical trials. Where possible the search was restricted to metastatic breast cancer (mBC) or advanced breast cancer. For MEDLINE, BIOSIS, EMBASE, the date span for the searches was from 1993 up until the date of each search. No date limits were specified for the Cochrane Library. For ASCO, the date span was from 2004 until present and for SABC and ESMO, it was from 2007 until present. There has only been one relevant ECCO/ESMO conference, this was in 2011. The ERG considers the range of databases selected and search strategies employed to be appropriate.

From its own searches of Ovid MEDLINE, Scopus (which includes EMBASE), ASCO and SABC on 6th January 2012, the ERG is confident all potentially relevant studies were identified by the manufacturer.

Eligibility Criteria

The inclusion/exclusion criteria employed by the manufacturer are clearly described in the manufacturer's submission (MS) and appear to be appropriate.

Inclusion Criteria

Published papers or abstracts which evaluated the following were included:

- Bevacizumab (BEV) had to be the major focus of the study, in order to eliminate references which merely mentioned BEV as part of a discussion of treatments for metastatic breast cancer (mBC) or other cancers.
- mBC had to be a major focus of the study, in order to eliminate papers addressing the use of BEV in other types of breast cancers, e.g., inflammatory breast cancer, or in other settings, e.g., neoadjuvant/adjuvant breast cancer, early breast cancer.
- Studies in which patients received BEV+capecitabine (CAPE), to be consistent with the BEV licence. Data addressing the efficacy of BEV in combination with other agents are not in line with this submission.
- Studies in which patients received study therapy for the first-line treatment of mBC, to be consistent with the BEV licence. Data addressing the efficacy of BEV+CAPE in second or later lines of treatment are not in line with the licence.
- Patient population had to consist predominantly of human epidermal growth factor receptor 2 negative (HER2-ve) patients (≥90%), as this is the patient population of interest for this appraisal.
- Efficacy endpoints associated with the treatment of mBC were the focus for the data, i.e., progression-free survival (PFS), overall survival (OS), response rates.
- Clinical trial data – rather than case reports, retrospective reviews, etc.
- Controlled studies
- Documents relating to humans – since work in animal models is not relevant to this application

Exclusion Criteria

Published papers or abstracts which evaluated the following were excluded:

- References which were not randomised, controlled phase II/III trials (such as phase I or safety studies or reviews)
- Studies where CAPE was not included, or where the difference between treatment arms was the addition of an agent other than BEV (e.g., BEV+CAPE vs BEV+CAPE+agent A)
- Studies which were in non-relevant populations, i.e. non first-line setting in metastatic disease, neoadjuvant/adjuvant therapy, early breast cancer, locally advanced breast cancer only or inflammatory breast cancer, human epidermal growth factor receptor 2 positive (HER2+ve) disease
- Studies where the dose or regimen of BEV or CAPE used was not UK standard practice
- References from ongoing studies providing insufficient data e.g. patients demographics/study designed described, but no efficacy data available

Abstracts were obtained for each of the RCT records identified and assessed for relevance. Where it was not possible to determine relevance from the abstract, the full paper or record was obtained and evaluated in more detail. For each excluded RCT, a rationale was recorded. It is not explicit whether the application of inclusion/exclusion criteria was cross checked by a second reviewer.

See Section 4 of the ERG report (see the "Availability of Companion Documents" field) for more information on clinical effectiveness analysis.

Cost-Effectiveness

Objective of the Manufacturer's Cost-effectiveness Literature Review

The MS states that the search was designed to evaluate whether *de novo* modelling was necessary in order to answer the decision problem set out in the scope issued by NICE. Outline details of the manufacturer's search strategy are presented in the MS. Dialogue Data-Star was used to search Embase, Medline, Medline (R) In-Process and EconLit, whilst the National Health Service Economic Evaluation Database (NHS EED) was searched using the University of York's Centre for Reviews and Dissemination website. The Data-Star searches were carried out on 16th November 2011 and the EconLit and NHS EED searches on 2nd December 2011. The date span for the searches was from 1993 up until the date of each search. The manufacturer appears not to have undertaken any searches of the unpublished literature; however, the ERG considers that finding any relevant unpublished studies is unlikely and concludes that the search strategy used by the manufacturer was appropriate.

Inclusion and Exclusion Criteria Used in Study Selection

Parameter	Inclusion Criteria	Exclusion Criteria
Population	Previously untreated advanced breast cancer patients	• Non-breast cancer patients • Previously treated patients
Intervention	Bevacizumab+capecitabine	-
Comparator	Capecitabine	-
Outcome	• Cost per quality-adjusted life year (QALY) gained • Cost per life year gained	-
Study Design	Economic evaluation (cost effectiveness analyses, cost utility analyses, cost minimisation analyses)	RCTs, observational data, budget impact assessments; during the record sifting process records were excluded if they were not a cost-utility analysis

Number of Source Documents

Clinical Effectiveness

One clinical trial was included in the review.

Cost Effectiveness

- No published cost-effectiveness studies were identified.
- The manufacturer submitted an economic model.

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare an assessment report. The Evidence Review Group (ERG) report for this technology appraisal was prepared by Liverpool Reviews and Implementation Group (LRiG) (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Data Extraction

No details of data extraction are provided by the manufacturer.

Quality Assessment

The evidence for clinical effectiveness is derived from only one manufacturer supported randomised controlled trial (RCT, RIBBON-1). Its quality was appropriately assessed using the minimum criteria for assessment of risk of bias in RCTs recommended in the Centre for Reviews and Dissemination guidance. This is reproduced in Table 6 of the ERG report (see the "Availability of Companion Documents" field).

The ERG generally agrees with the manufacturer in relation to how the study questions were assessed. However, in relation to the third study question, the ERG notes some imbalances (differences of 5% or more) between the two treatment arms (see Table 6 and section 4.2 of the ERG report).

Evidence Synthesis

The RCT RIBBON-1 compared bevacizumab (BEV)+capecitabine (CAPE) to CAPE. No RCTs were identified that compared BEV+CAPE to vinorelbine (VIN). Thus no meta-analysis could have been undertaken to compare BEV+CAPE to CAPE or BEV+CAPE to VIN.

In the absence of direct comparisons of BEV+CAPE to VIN, the manufacturer may have attempted to conduct a mixed-treatment comparison. However, the only known RCT to compare VIN to CAPE was a small RCT that was halted prematurely. The ERG doubts whether suitable trials would have been available.

There also appear to be valid practical reasons why VIN is a less suitable comparator than CAPE, i.e., it is much less likely to be preferred by clinicians in clinical practice. Therefore the ERG does not believe a mixed treatment comparison would have added any value to the evidence base.

See Section 4 of the ERG report for more information on clinical effectiveness analysis.

Cost Effectiveness

Summary and Critique of Manufacturer's Submitted Economic Evaluation by the ERG

NICE Reference Case Checklist

Table 22 of the ERG report shows how closely the manufacturer's submitted economic evaluation accords with the requirements for a base-case analysis as set out in the NICE reference case checklist. In general the manufacturer's analysis matches the requirements set by NICE.

Model Structure

Three health states are used to model disease progression. All patients enter the model in the progression free survival (PFS) health state and in each month can either progress to a 'worse' health state (i.e. from PFS to Progressed or Death, or from Progressed to Death) or remain in the same health state. Second-line therapy is not considered in the model. The model has been developed in Microsoft Excel and has a one month cycle length, includes a half-cycle correction as recommended by NICE and the time horizon is set at 15 years. The model structure is shown in Figure 1 of the ERG report.

Sensitivity Analyses

The manufacturer varied costs (± 40%), utilities (± 25%), discount rates (0-6%) and the time horizon (± 5 years); and also fitted alternative survival curves (using Gompertz curves for PFS and progressive disease [PD] and a Weibull curve for time to off treatment [TTOT]). The results presented in Table 31 of the ERG report demonstrate that the incremental cost-effectiveness ratio (ICER) for BEV+CAPE in these patients is most sensitive to assumptions concerning all utilities, particularly those relating to PD and the PD parametric curve.

Model Validation and Face Validity Check

It is reported that no clinical experts were consulted in the development of this economic model. The manufacturer felt that having recently held two advisory boards to obtain validation of the assumptions and inputs utilised in other metastatic breast cancer (mBC) economic models (BEV in combination with a taxane and trastuzumab in combination with an aromatase inhibitor) rendered further validation of resource use inputs unwarranted.

Detailed Critique of Manufacturer's Economic Model

Table 35 of the ERG report summarises the ERG's appraisal of the economic evaluation conducted by the manufacturer using the Drummond 10-point checklist.

See Sections 5 and 6 of the ERG report for more information on methods of cost-effectiveness analysis.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Considerations

Technology appraisal recommendations are based on a review of clinical and economic evidence.

Technology Appraisal Process

The National Institute for Health and Clinical Excellence (NICE) invites 'consultee' and 'commentator' organisations to take part in the appraisal process. Consultee organisations include national groups representing patients and carers, the bodies representing health professionals, and the manufacturers of the technology under review. Consultees are invited to submit evidence during the appraisal and to comment on the appraisal documents.

Commentator organisations include manufacturers of the products with which the technology is being compared, the National Health Service (NHS) Quality Improvement Scotland and research groups working in the area. They can comment on the evidence and other documents but are not asked to submit evidence themselves.

NICE then commissions an independent academic centre to review published evidence on the technology and prepare an 'assessment report'. Consultees and commentators are invited to comment on the report. The assessment report and the comments on it are then drawn together in a document called the evaluation report.

An independent Appraisal Committee then considers the evaluation report. It holds a meeting where it hears direct, spoken evidence from nominated clinical experts, patients and carers. The Committee uses all the evidence to make its first recommendations, in a document called the 'appraisal consultation document' (ACD). NICE sends all the consultees and commentators a copy of this document and posts it on the NICE Web site. Further comments are invited from everyone taking part.

When the Committee meets again it considers any comments submitted on the ACD; then it prepares its final recommendations in a document called the 'final appraisal determination' (FAD). This is submitted to NICE for approval.

Consultees have a chance to appeal against the final recommendations in the FAD. If there are no appeals, the final recommendations become the basis of the guidance that NICE issues.

Who Is on the Appraisal Committee?

NICE technology appraisal recommendations are prepared by an independent committee. This includes health professionals working in the NHS and people who are familiar with the issues affecting patients and carers. Although the Appraisal Committee seeks the views of organisations representing health professionals, patients, carers, manufacturers and government, its advice is independent of any vested interests.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

Summary of Appraisal Committee's Key Conclusions

Availability and Nature of Evidence

The Committee considered the cost effectiveness of bevacizumab and capecitabine compared with capecitabine alone based on the manufacturer's model and critique by the Evidence Review Group (ERG). The Committee was aware that the manufacturer had based the economic evaluation on the subgroup of patients who had previously received a taxane rather than the Committee's preferred choice of the whole capecitabine cohort (the intention-to-treat [ITT] population). The Committee noted the manufacturer's and ERG's statements that an analysis of the ITT population would result in a larger incremental cost-effectiveness ratio (ICER) than for the subgroup included in the base-case analysis. The Committee agreed with this assessment.

Uncertainties Around and Plausibility of Assumptions and Inputs in the Economic Model

The Committee noted the explorations made by the ERG to the costs of therapy and concluded that these adjustments were appropriate. The Committee noted the ERG's concerns around the rank preserving structural failure time method used by the manufacturer to account for the effect of crossover to open-label bevacizumab in the modelling of survival in the progressed disease state. The Committee discussed the ways in which the analyses were adjusted for crossover but was unclear as to the most appropriate method without introducing bias. The Committee also noted that the subsequent treatments had not been modelled, which in combination with the impact of crossover, could have led to confounding of the overall survival results.

The Committee discussed that it was unexpected that the costs of administration and pharmacy time associated with bevacizumab plus capecitabine would be lower than the costs for capecitabine alone. The Committee concluded that despite the incorporation of National Health Service (NHS) tariffs, this discrepancy contributed to the uncertainty associated with the results of the manufacturer's economic model.

The Committee was also aware that a disutility from adverse events had not been applied in the manufacturer's model, despite utility estimates being available in the literature to account for adverse events, and it was likely that this could have resulted in underestimated ICERs.

Incorporation of Health-Related Quality of Life Benefits and Utility Values

The Committee noted that no quality of life data had been collected in the trial and that the economic analysis included utility values from a literature review. The Committee was also aware that a disutility for adverse events had not been applied in the manufacturer's model, despite utility estimates being available in the literature to account for adverse events, and it was likely that this could have resulted in underestimated ICERs.

Have Any Potential Significant and Substantial Health-Related Benefits Been Identified That Were Not Included in the Economic Model, and How Have They Been Considered?

The Committee recognised the novel mode of action of bevacizumab, which may benefit breast cancer patients whose treatment options are limited. However, it considered that there were no additional gains in health-related quality of life over those already included in the quality-adjusted life years (QALY) calculations.

Are There Specific Groups of People for Whom the Technology Is Particularly Cost Effective?

The Committee concluded that the results from the prior taxane subgroup of the RIBBON-1 trial were not sufficiently robust to use for the development of guidance. The Committee only considered the economic analysis based on this subgroup to establish a benchmark for the incremental cost per QALY gained for the ITT population.

What Are the Key Drivers of Cost Effectiveness?

The costs of therapy adopted in the manufacturer's model, the impact of crossover and lack of modelling of subsequent treatments were key drivers of uncertainty around cost effectiveness.

Most Likely Cost-Effectiveness Estimate (Given as an ICER)

The Committee concluded that given all of the uncertainties, it was not possible to determine the most plausible ICER for bevacizumab plus capecitabine compared with capecitabine alone for the subgroup of patients who were previously treated with a taxane. However, it was convinced that the ICER would be higher than the ICER of £82,000 per QALY gained resulting from the ERG explorations. The Committee considered that the ICER for bevacizumab plus capecitabine compared with capecitabine alone in the ITT population would be even higher.

See Sections 3 and 4 of the original guideline document for details of the economic analysis provided by the manufacturer, the Evidence Review Group comments, and the Appraisal Committee considerations.

Method of Guideline Validation

External Peer Review

Description of Method of Guideline Validation

Consultee organisations from the following groups were invited to comment on the draft scope, Assessment Report and the Appraisal Consultation Document (ACD) and were provided with the opportunity to appeal against the Final Appraisal Determination.

- Manufacturer/sponsors
- Professional/specialist and patient/carer groups
- Commentator organisations (without the right of appeal)

In addition, individuals selected from clinical expert and patient advocate nominations from the professional/specialist and patient/carer groups were also invited to comment on the ACD.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

The Appraisal Committee considered clinical and cost-effectiveness evidence and a review of this submission by the Evidence Review Group. For clinical effectiveness, one randomised controlled trial (RCT) was the main source of evidence. For cost-effectiveness, the manufacturer's model was considered.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Potential Benefits

Appropriate recommendation for the use of bevacizumab in combination with capecitabine for the first-line treatment of metastatic breast cancer

Potential Harms

The summary of product characteristics lists the following adverse reactions that may be associated with bevacizumab treatment: gastrointestinal perforations, fistulae, wound healing complications, hypertension, proteinuria, arterial and venous thromboembolism, haemorrhage, pulmonary haemorrhage/haemoptysis, congestive heart failure, reversible posterior leucoencephalopathy syndrome, hypersensitivity/infusion reactions, osteonecrosis of the jaw, ovarian failure and neutropenia.

For full details of adverse reactions and contraindications, see the summary of product characteristics.

Contraindications

Contraindications

For full details of adverse reactions and contraindications, see the summary of product characteristics.

Qualifying Statements

Qualifying Statements

- This guidance represents the views of the National Institute for Health and Clinical Excellence (NICE) and was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

Implementation of the Guideline

Description of Implementation Strategy

- The Secretary of State and the Welsh Assembly Minister for Health and Social Services have issued directions to the National Health Service (NHS) in England and Wales on implementing National Institute for Health and Clinical Excellence (NICE) technology appraisal guidance. When a NICE technology appraisal recommends use of a drug or treatment, or other technology, the NHS must usually provide funding and resources for it within 3 months of the guidance being published. If the Department of Health issues a variation to the 3-month funding direction, details will be available on the NICE website. When there is no NICE technology appraisal guidance on a drug, treatment or other technology, decisions on funding should be made locally.
- The technology in this appraisal may not be the only treatment for metastatic breast cancer. Therefore, if a NICE technology appraisal recommends use of a technology, it is as an option for the treatment of a disease or condition. This means that the technology should be available for a patient who meets the clinical criteria set out in the guidance, subject to the clinical judgement of the treating clinician. The NHS must provide funding and resources when the clinician concludes and the patient agrees that the recommended technology is the most appropriate to use, based on a discussion of all available treatments.
- NICE has developed tools to help organisations put this guidance into practice (listed below). These are available on the NICE website (http://guidance.nice.org.uk/TA263).

- A costing statement explaining the resource impact of this guidance.

Implementation Tools

Clinical Algorithm

Patient Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

National Institute for Health and Clinical Excellence (NICE). Bevacizumab in combination with capecitabine for the first-line treatment of metastatic breast cancer. London (UK): National Institute for Health and Clinical Excellence (NICE); 2012 Aug. 48 p. (Technology appraisal guidance; no. 263).

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2012 Aug

Guideline Developer(s)

National Institute for Health and Care Excellence (NICE) - National Government Agency [Non-U.S.]

Source(s) of Funding

National Institute for Health and Clinical Excellence (NICE)

Guideline Committee

Appraisal Committee

Composition of Group That Authored the Guideline

Committee Members: Professor Peter Clark (*Chair*), Consultant Medical Oncologist, Clatterbridge Centre for Oncology; Professor Jonathan Michaels (*Vice Chair*), Professor of Clinical Decision Science, University of Sheffield; Professor Kathryn Abel, Director of Centre for Women's Mental Health, University of Manchester; Professor Darren Ashcroft, Professor of Pharmacoepidemiology, School of Pharmacy and Pharmaceutical Sciences, University of Manchester; Dr Matthew Bradley, Therapy Area Leader, Global Health Outcomes, GlaxoSmithKline; Dr Ian Campbell, Honorary Consultant Physician, Llandough Hospital; Professor Usha Chakravarthy, Professor of Ophthalmology and Vision Sciences, The Queen's University of Belfast; Professor Simon Dixon, Professor of Health Economics, University of Sheffield; Gillian Ells, Prescribing Advisor, NHS Sussex Downs and Weald; Dr Jon Fear, Consultant in Public Health Medicine, Head of Healthcare Effectiveness NHS Leeds; Paula Ghaneh, Professor of Surgery, University of Liverpool; Dr Susan Griffin, Research Fellow, Centre for Health Economics, University of York; Professor Carol Haigh, Professor in Nursing, Manchester Metropolitan University; Professor John Hutton, Professor of Health Economics, University of York; Professor Peter Jones, Emeritus Professor of Statistics, Keele University; Dr Steven Julious, Senior Lecturer in Medical Statistics, University of Sheffield; Rachel Lewis, Advanced Nurse Practitioner, Manchester Business School; Professor Paul Little, Professor of Primary Care Research, University of Southampton; Professor Katherine Payne, Professor of Health Economics, University of Manchester; Dr John Radford, Director of Public Health, Rotherham Primary Care Trust; Dr Peter Selby, Consultant Physician, Central Manchester University Hospitals NHS Foundation Trust; Dr Brian Shine, Consultant Chemical Pathologist, John Radcliffe Hospital, Oxford; Dr Murray D Smith, Associate Professor in Social Research in Medicines and Health, University of Nottingham; Paddy Storrie, Lay Member; Charles Waddicor, Chief Executive, NHS Berkshire

Financial Disclosures/Conflicts of Interest

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site .

Availability of Companion Documents

The following are available:

- Bevacizumab in combination with capecitabine for the first-line treatment of metastatic breast cancer. Costing statement. London (UK): National Institute for Health and Clinical Excellence (NICE); 2012 Aug. (Technology appraisal guidance; no. 263). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site .
- Bevacizumab in combination with capecitabine for the first-line treatment of metastatic breast cancer. Evidence Review Group report. Liverpool (UK): Liverpool Reviews and Implementation Group, University of Liverpool; 2012 Feb 23. 78 p. Electronic copies: Available in PDF from the NICE Web site .
- Advanced breast cancer overview. NICE pathway. London (UK): National Institute for Health and Clinical Excellence (NICE); 2012 Aug.

(Technology appraisal guidance; no. 263). Electronic copies: Available from the NICE Web site .

Patient Resources

The following is available:

- Bevacizumab in combination with capecitabine for the first-line treatment of metastatic breast cancer. Understanding NICE guidance. Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence (NICE); 2012 Aug. 5 p. (Technology appraisal guidance; no. 263). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence Web site .Also available in Welsh from the NICE Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI Institute on October 15, 2012.

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